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The mutuality metaphor: understanding healthcare provision in NHS Scotland

Introduction

The role and definition of the ‘third sector’ in public service provision continues to be a hugely contested terrain (Macmillan, 2010; Howieson and Hodges, 2014). Central to these debates are whether there is, in fact, a coherent sector (Alcock, 2010) and, if so, what it should be called (Billis, 2010). With regards to one of the sector subcomponents — social enterprise — Teasdale (2011: 99) notes a “*bewildering array of definitions and explanations*”. The context of healthcare represents a case in point for such potential ambiguities and disputes as the sector sees the rise in social enterprise, cooperatives, mutuals, and charities as a possible means to deliver services (e.g. Millar, 2012).

In Scotland, the *Better Health Better Care Action Plan* (Scottish Government, 2007) set out how the Government intends to strengthen public ownership of its National Health Service (NHS Scotland) through the promotion of mutuality as its organising concept. According to *Better Health Better Care* (Scottish Government, 2007: 5):

“Mutual organisations are designed to serve their members. They are designed to gather people around a common sense of purpose. They are designed to bring the organisation together in what people often call ‘co-production.’”

Some 8 years on from the publication of *Better Health Better Care*, NHS Scotland is continuing to build the basis for a mutual NHS. On reflection, however, it is suggested that there are several issues that still need to be thought through about how to implement further this mutual health policy in Scotland. A significant issue is, I contend, the definitional problem and importantly, how ‘mutuality’ is communicated.

This Viewpoint aims to analyse how mutuality in the provision of Scottish healthcare has been introduced. Its definitional problem will be explored with a particular focus on how mutuality is (or perhaps should be) communicated. It concludes setting out a way forward will suggest that further debate is required to enable mutual healthcare, and its delivery, to evolve and thrive over a longer period with a strong focus on practical solutions. It is hoped that this analysis will help researchers and practitioners alike to appreciate further the philosophy of healthcare mutuality and to understand that it actually may be more instructive to think of, and communicate, mutuality as a metaphor to aid understanding of the openness and fluidity found in NHS Scotland today.

Defining Mutuality in the provision of Scottish healthcare

The Scottish Government offers a vision of mutuality which values stakeholders as co-producers of healthcare with a ‘common sense of purpose’. However, many professionals within NHS Scotland — and the public in general — struggle to define what a mutual NHS means for them (Howieson and Fenwick, 2014). This ‘definitional problem’ is echoed by the Scottish Partnership Forum (2009) who commented on the difficulty of staff understanding mutuality. In order to explain better what ‘mutuality’ means, the Forum indicated that the government may need to move away from that term in explaining to the public and staff why mutuality is important.

At the basic level, the Concise Oxford Dictionary (1996) offers that mutualism is: “*The doctrine that mutual dependence is necessary to social well-being*”. In looking for a working definition, the academic literature is also somewhat problematic. Mutuality is a concept that Lea and Mayo (2002:8) considered in some detail. They offer: “*at its most simple, mutuality is an ‘institutionalised value-based model of reciprocity’ which may be used to describe mutual models of ownership or decision-making, mutual methods of doing business or simply a mutual ethos.*” More specifically, James (2000) suggests that mutuality is: “*a contractual arrangement...between a group of people, wherein it is understood that no member of the group stands in a superior position to any other in terms of voting power, ownership rights or accrued benefits.*” Mutuality may also refer to ‘social mutualism’ — in this approach, employees and service users have a greater say in the management, operation, and delivery of public services. This model of public service delivery (social mutualism) offers a third way compared to the market and state models of service provision (Diamond, 2011).

Beswick (2012) also considers 2 relevant and competing definitions: “*a mutual relationship is one in which the relationship between service provider and user is transcended, through the users collectively delivering the service themselves, effectively doing away with the concept of service provider*” (Simmons et al 2006: 10); and “*mutualism could be described as a condition of interaction between 2 groupings where both derive decisive benefits; for example, increased sustainability*” (Aghren, 2009: 400). Although there is emphasis on the ideas of egalitarianism (shared benefits) and responsibilities, differences in emphasis on the relationship between service users and providers, on closer inspection, become apparent. Aghren (2009), for example, focuses on the outcomes of any given relationship, retaining the identities of the 2 parties. Simmons et al (2006), by contrast, emphasise the nature of the relationship itself, the ‘transcend[ing]’ of the distance between user and provider recalling the process of ‘co-production’.

Howieson (2013:72) makes another interesting observation when he restates *Better Health Better Care* (Scottish Government, 2007: 5): “*whilst the Scottish NHS is not constituted legally as a*

mutual, the concept of a mutual organisation sits 'extremely comfortably' with the objectives of healthcare delivery in Scotland." This separation of the concept or idea of mutuality from a legal entity or specific organisation structure is useful, allowing for a broader definition of mutuality, which is not purely formalistic. Nonetheless, one ought not to reject structure out of hand — Beswick (2012), for example, notes that in a paper for the management consultant firm Accenture, Cooper (2012: 3) focuses on mutuality as a structure, arguing that: *"an old organizational form [i.e. mutuality] is offering new hope to governments as they strive to manage fiscal austerity and rising citizen demands."* Far from narrowing the definition, however, Cooper (2012) suggests that the term 'mutual' covers a broad spectrum of models placing a series of disparate organisational forms from co-operative to social enterprise on a continuum. The uniting feature, he claims, is a focus on achieving social rather than financial objectives. Similarly, Simmons et al (2006) point to the interest in mutuality as arising out of a loss of faith in traditional hierarchies, specifically those 'large, rigid bureaucracies of the post-war welfare state'. What is significant here, however, is that mutual forms may be viewed in opposition to bureaucratic forms.

Elsewhere, Howieson (2013:74) makes perhaps a more powerful case when defining what a mutual healthcare system may look like by arguing that: *"Mutuality in healthcare provision necessitates that all people with a significant interest in that provision (whether as actual or potential users, patients and their families, friends and associates, medical professionals, and other 'deliverers') seek awareness and accommodation of the interests of the public, and thereby seek to enable the people who make up those publics to enhance their wellbeing. Indeed, a health policy that is truly founded on mutuality, therefore, must enable articulation of the public interest."*

A more fruitful approach is, in fact, suggested by Sturgeon who, in her Foreword to *Better Health, Better Care* (Scottish Government, 2007: v), makes a point of noting that in: *"stressing public ownership through a more mutual approach, we distance NHS Scotland still further from market orientated models."* She is not the only person to approach it from such an angle: Philips (2010), for instance, writes of renewed interest in mutuality and community ownership as a result of public scorn for the 'casino capitalism' that drove the financial crisis. In this respect, there is clearly a relevant strand of thinking which sees mutuality and shared ownership as a reaction against a failure of individualist, consumerist ideologies. Howieson (2013: 72) for example sets mutuality in opposition to 'competitive' or 'adversarial' relationships between stakeholders, i.e. those typical of the *"privileging of teleological action."* This is useful since, in addition to a mutual/consumerist binary, Howieson adds a mutualistic/teleological one.

How a mutual health policy is communicated and how a mutual health policy should, perhaps, be communicated

In their reflections on public participation in service delivery, Barnes et al (2003: 396-397) raise a number of interesting points regarding whether or not we are seeing new forms of mediation between the state and its citizens. In looking to move beyond the established typologies of 'consumer/customer' or a 'client in an administrative state' as citizens become more involved in public service provision, they argue that the terms upon which they engage may become rather amorphous and fluid. In other words, the point is not, as Birchall (2008: 93) has it, that *"it should be up to users as much as to the providers as to where on the map of possible relationships they want to be,"* rather, the reality is that users may engage in services through an unpredictable range of possible interactions.

Evidently, I feel that it is such perspectives that are the key to understanding (and defining) further the mutual healthcare philosophy and its subsequent communication. The existence of ambiguity regarding whether mutuality represents consumerist, teleological, or bureaucratic assumptions should not, however, negate the usefulness of the term ‘mutuality’. In accepting that ‘mutuality’ is an ill-defined and partial term, but using it as a lens through which to better understand aspects of healthcare and its delivery in NHS Scotland, one is reminded of Morgan’s text, ‘Images of Organisation’ in which he argues that we understand organisations through metaphor. Metaphor *“frames our understanding in a distinctive yet partial way... [it] invites us to see the similarities but ignore the differences”* (Morgan, 1997: 4-5). In short, it actually may be more instructive to think of — and communicate — mutuality as a metaphor to aid understanding of the openness and fluidity found in NHS Scotland. This approach — *“it should be up to users as much as to the providers as to where on the map of possible relationships they want to be”* (Birchall, 2008:93) — is not present in the extant policy or practitioner literature in NHS Scotland.

Conclusion

As an approach to democratisation in healthcare management, and in healthcare generally, a mutual health policy remains relatively under-developed, especially at the operational and strategic levels of state healthcare systems. This mutual philosophy and policy, then, may be consistent with this publicly-funded body in terms of the funders having a greater say in their service, and making decisions about the shape and structure of healthcare across Scotland.

On reflection, searching for a definition of mutuality may not be actually that important; rather, mutuality, as defined in healthcare, should be flexible and responsive, moving back and forward between two points until consensual agreement is reached. It may represent a change from historic community values of entering the ‘caring’ profession and ‘fixing’ people to releasing power to people who are in control of their lives for the majority of the time and allowing them to be given the choice of having more control over their health, their care, and their wellbeing. As Birchall (2008: 90) notes: *“[mutuality] goes against many bureau-professionals’ deeply-held beliefs in the value of technical competence and threatens the interests of those who find a paternalistic relationship with ‘their’ service users psychologically rewarding.”*

Perhaps, then, the end point is a re-thinking of mutuality: what it means and how it is executed.

It is considered, therefore, that there is a need for more public, professional, and academic debate to explore and clarify its implementation, and how it is to be led. This debate should offer the opportunity for co-producing healthcare by existing or emerging publics, without defining these restrictively in health, social, political, cultural, geographic or any other terms. What may be necessary for such debates to come into being is accessibility from the plurality of actual or potential publics who are seeking positive health outcomes, not simply for themselves but with a growing awareness and accommodation of the interests of other publics. This must be provided whilst recognising the daily imperatives that NHS leaders must face.

The challenge of mutuality may then be as much about the co-creation of outcomes and the inherent mutual healthcare needs to be considered at different levels of application — individual, service, and national. It may mean something different in each case. What we will need to focus on

is whether these different needs (and interpretations of these needs) can co-exist without contradiction. Only in this way, is it likely that a direction of travel will emerge. It will be about developing an approach and reviewing 'as we go' to determine progress towards achievement. As the different elements healthcare needs merge and are adjusted (between user and provider), they will routinely require reassessment to realign with the mutual aim.

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